**** Notation: RYAN WHITE PROGRAM PRESCRIPTION DRUG FORMULARY COMMENTS***

Updates Effective 02/08/2011

A	***REVISED*** ***THESE MEDICATIONS MAY BE COVERED BY THE RYAN WHITE PART A/MINORITY AIDS INITIATIVE PROGRAMS WHEN THE MEDICATIONS ARE NOT AVAILABLE THROUGH THE STATE OF FLORIDA'S AIDS DRUG ASSISTANCE PROGRAM (ADAP).***
B	*In order for a client to obtain this medication through the Part A or MAI Programs, one of the two conditions (histoplasmosis or aspergillosis) must have been identified and documented in the client's chart by his/her physician. In addition, the* ***Ryan White Program Letter of Medical Necessity for Sporanox*** *is required. Part A or MAI funds may only be used to cover one of the two conditions. (Rev. 5/12/2008)*
C	*(Notation no longer applicable.)*
D	*These nutritional supplements are available in powder form only and require a referral from both a Physician and a Nutritionist.*
E	*(Notation no longer applicable.)*
F	*Part A or MAI funds may only be used to reimburse for this medication for the treatment of Toxoplasmosis, and must be written as such on the prescription.*
G	*(Notation no longer applicable.)*
H	*To qualify for Part A or MAI coverage, the patient's testosterone level must be below a normal reading. Prescribing physicians must include the patient's most recent testosterone level on the prescription for this medication. If this information is not provided on the prescription, Part A or MAI will not cover the cost of this medication.*
I	*(Notation no longer applicable.)*
J	*Part A or MAI funds may only be used to reimburse for these medications for the treatment of indications experienced by HIV+ children 12 years and under. These medications are only available in liquid or suspension form.*
K	*(Notation no longer applicable.)*
L	*In order to receive Eprosartan (Teveten) through the Ryan White Part A or MAI Programs, the patient must have had a prior history of intolerability to the use of Angiotensin Converting Enzyme (ACE) Inhibitors.*
M	*(Notation no longer applicable.)*
N	*(Notation no longer applicable.)*
O	*(Notation no longer applicable.)*
P	*Ofloxacin (Ocuflox) is restricted to ophthalmic/ophthalmologist use only.*
Q	*Physicians prescribing Neupogen to patients needing to access Part A or MAI pharmaceutical services are required to complete a Ryan White Program Prior Authorization Form for Neupogen (Filgrastim). Prescribing physicians* **must** *submit the Ryan White Program Prior Authorization Form to the Part A or MAI pharmacy along with the* **original** *prescription and* **lab** *results dated within the last two (2) months.*
R	*Physicians prescribing Procrit or Epogen to patients needing to access Part A or MAI pharmaceutical services are required to complete a Ryan White Program Prior Authorization Form for Procrit or Epogen (Epoetin Alpha). Prescribing physicians* **must** *submit the Ryan White Program Prior Authorization Form to the Part A or MAI pharmacy along with the* **original** *prescription and* **lab** *results dated within the last two (2) months.*
S	*There is no generic equivalent for this new brand name product.*

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Updates Effective 02/08/2011

T	*REVISED* *This drug is not indicated as a sleep aid and should only be used to treat bipolar disorders and schizophrenia.*
U	*The **Ryan White Program Letter of Medical Necessity for Enfuvirtide (Fuzeon)** is required. The primary medical provider must certify it to be medically necessary to add Enfuvirtide (Fuzeon) to this patient's antiretroviral regimen. The patient has been on Enfuvirtide (Fuzeon) through another funding source but this funding source is no longer available. This condition necessitates Ryan White Part A or MAI coverage for continuity of care. In addition, the patient must meet one (1) of the following appropriate criteria below:* *1. The patient is eligible for the AIDS Drug Assistance Program (ADAP) and there is a completed application pending approval. A new prescription is allowed for a maximum of **60 days** and no refill authorizations are accepted;* **OR** *2. The patient is not eligible for ADAP and must be covered under Ryan White Part A or MAI pending another payment source. A new prescription is allowed for a maximum of **90 days** and no refill authorizations are accepted.*
V	*The **Ryan White Program Letter of Medical Necessity for Tipranavir (Aptivus)** is required. As the prescribing healthcare provider, it is his/her considered opinion that Tipranavir (Aptivus) is medically necessary for the patient, and should be added to his/her antiretroviral regimen. In addition, the prescribing healthcare provider must certify that the following criteria have been met:* *1. The patient has failed treatment with Lopinavir/ritonavir (Kaletra) and all three classes of antiretorvirals;* **AND** *2. The healthcare provider has fully discussed all issues and consequences related to non-adherence with the patient.*
W	*This medication was added to the Ryan White Program Prescription Drug Formulary effective March 1, 2008. Before prescribing Maraviroc (Selzentry) to any client, physicians and other prescribing clinicians must complete a **Ryan White Program Letter of Medical Necessity for the Trofile Co-Receptor Tropism Assay** (billing encounter code: TROF). Providers must adhere to the "Sample Collection and Handling Requirements for PhenoSense™ HIV, GeneSeq™ HIV, PhenoSense GT™, PhenoSense™ Entry, and Trofile™ Co-Receptor Tropism Assays," when obtaining the specimen for delivery to the laboratory. A **Ryan White Program Letter of Medical Necessity for Selzentry (Maraviroc)** is also required prior to dispensing the medication.*
X	*This medication was added to the Ryan White Program Prescription Drug Formulary effective March 1, 2008. The Florida Department of Health issued and Interoffice Memorandum, dated January 31, 2008,with information regarding Intelence (Etravirine). Accompanying this Memorandum was a document titled "Intelence (Etravirine) Tablets – Full Prescribing Information." This information comes from the manufacturer. It is extremely important for providers and clients to understand the prescribing information related to Intelence (Etravirine).*
Y	*The **Ryan White Program Letter of Medical Necessity for Roxicodone (Oxycodone) and Percocet (Oxycodone/APAP),** approved by the Miami-Dade HIV/AIDS Partnership on August 11, 2008, is required. In addition, physicians prescribing these pain medications must adhere to the related legislation found in Florida Administrative Code 64B8-9.013, Standards for the Use of Controlled Substances for the Treatment of Pain, and Florida Statutes 458.309 and 458.331.*
Z	*Lantus, Levemir, Humalog and Novolog are restricted to dispensing in vial form only. Miami-Dade County Office of Grants Coordination staff is authorized to make an exception to this restriction subject to consulting with the medical provider.*
AA	*Strattera (Atomoxetine) is restricted to prescribing by a psychiatrist for patients with a diagnosis of attention-deficit hyperactivity disorder (ADHD) and a history of substance abuse only.*
BB	*This medication was added to the Ryan White Program Prescription Drug Formulary effective September 13, 2010 as a cost saving measure to prevent costly complications for anorectal surgery patients. This medication is restricted to anorectal surgery patients with a maximum utilization of a 30-day supply. This medication is also limited to generic only.*
CC	***Where available, it is preferred that clients who can get this medication from a Patient Assistance Program (PAP) or low-cost pharmacy (Publix, Target, etc) are strongly encouraged to do so PRIOR TO accessing the medication through the Ryan White Program. A 10-day supply of these medications may be provided to Ryan White Program clients if there is a delay in accessing medications through PAPs or low-cost pharmacies. Ativan, Effexor, Klonopin, Restoril, and Strattera do not have a PAP or low-cost pharmacy program.***
DD	***This medication is temporarily limited to treatment for Mycobacterium avium-intracellulare (MAI) , Mycobacterium avium complex (MAC), and Pneumocystis carinii pneumonia (PCP) only, until further notice.***
EE	***Ranitidine must be used (now allowable in 75mg, 150mg, and 300mg dosages) for at least one month prior to filling a prescription for Omeprazole, unless the client has failed on Ranitidine or if complications require the use of Omeprazole only. Documentation in the client chart must support the failure of Ranitidine in the client's case.***
FF	***Prenatal vitamins are restricted to pregnant women only.***
GG	***Vitamin B6 is restricted to clients who are taking Isoniazid (INH).***